

# **Obesity Prevention Guidelines for Children**

*For AHCCCS Medical Nutrition Therapy/Dietitian Providers*

## **Assessment**

### **A. Clinical data**

1. Anthropometrics data
  - a. The child's PCP evaluates growth yearly during well child visits.
  - b. The child's height and weight is plotted on a standard growth chart.
  - c. A current Body Mass Index (BMI) is calculated and plotted to determine what "Tier" they are at (BMI can be calculated by dividing weight by the square of the height (kg/m<sup>2</sup>) or by referring to a BMI chart).
    1. *Tier 2- "At-Risk"*--a child at the 75<sup>th</sup> percentile BMI needs to be referred for medical nutrition therapy/dietitian (2 visits per year)
    2. *Tier 3*--a child at the 85<sup>th</sup> percentile BMI needs to be referred for medical nutrition therapy/dietitian (4 visits per year)
    3. *Tier 4*--a child at the 95<sup>th</sup> percentile or greater BMI needs to be referred for medical nutrition therapy/dietitian (1 time per week for 16 weeks with follow up at 3, 6, 9 and 12 months)
2. The following laboratory values and dates is evaluated: Hgb, Hct, thyroid panel, triglycerides, lipid profile, glucose tolerance test lab values Plus, any other labs that may be ordered by the PCP.
3. Medications, vitamin and mineral supplements, and other nutrition supplements (e.g., omega 3 supplements, flaxseed, etc)
4. Current physical activity is assessed.
5. Medical and family history is assessed.
6. Family and psychosocial issues including family support, family history of eating disorders and obesity, stress issues, food security issues, family attitudes about weight, dieting is accessed.
7. PCP's physical examination is assessed

## B. Interview client

1. Medical history--a thorough medical history is conducted to identify any underlying syndromes or secondary complications, which may affect weight status and/or design of the intervention.
2. Family history
  - a. Screen for familial risks of obesity such as eating disorder, Type 2 diabetes mellitus, cardiovascular disease, hypertension, dyslipidemia, and gallbladder disease in, siblings, parents aunts, uncles, or grandparents.
  - b. Screen for other risk factors such as genetics, socioeconomic factors, ethnic factors, cultural factors, and environmental factors.
3. Dietary History
  - a. An assessment of the child's eating practices (quantity, quality, and timing) is conducted to identify both foods and patterns of eating that may lead to excessive caloric intake.
  - b. At the first medical nutrition therapy/dietitian meeting obtain a *One Day Food Record*, a *Daily Food and Physical Activity Log* or other diet record or food frequency tool. These diet records need to be analyzed to determine nutritional intake and pinpoint problem areas to be worked on.

The One Day Food Records should includes:

- All foods eaten including beverages
- Quantity of food and beverages eaten by using paper or rubber food models and measuring cups/spoons to help assess amounts
- How the food was prepared

Review the record with the family to ensure the food items are specific and portion size is correct.

Suggested tool(s): Attachment D - *One Day Food Record* from ADA Nutrition Care Manual, and Attachment F- *My Daily Food and Physical Activity Log* from Shape up America's Food and Physical Activity Log:  
<http://www.shapeup.org>.

4. Physical Activity History
  - a. Obtain a history of physical activity to quantify activity levels as well as time spent in sedentary behaviors (e.g., watching television or video, playing video games).
  - b. Screen for any history of medical conditions that limit or are contraindicated to physical activity should be noted (e.g., asthma).

Suggested tool(s): Attachment B - AHCCCS Physical Activity Assessment Tool Questions and Bright Futures Physical Activity Questions

5. Review Physical Examination--completed by PCP
6. Review Laboratory Testing The choice of laboratory tests is determined by the degree of overweight, family history, and the physical examination. Tier 3 & 4 patients should have these tests done: lipid panel including triglycerides, blood glucose (glucose tolerance), acanthosis nigricans, and blood pressure. There may be other tests ordered by the PCP.
7. Review Psychological Evaluation--to be done by therapist to include motivational/behavioral therapy (2 visits per year for Tier 2; 4 visits per year for Tier 3; and 1 time per week for 16 weeks with follow up at 3, 6, 9 and 12 months)

## **Intervention**

A. Determine most appropriate treatment based on risk level.

1. Prevention--Tier 2-At-Risk (BMI is 75<sup>th</sup> %)
  - a. Focus on incorporating preventative strategies as a part of a healthy lifestyle. Strategies include health eating behaviors, regular physical activity, and reducing sedentary activities (e.g., watching television and videotapes, and playing computer games).
  - b. The primary goal is to teach and model healthy and positive attitudes toward food and physical activity without emphasizing body weight.
  - c. Behavior techniques for a healthy eating and physical activity behaviors are encouraged.

2. Maintenance--Tier 3 (BMI is 85<sup>th</sup> %).

The first step is to maintain baseline weight. This can be achieved through modest changes in diet and activity. A gradual decline in BMI percentile as children grow in height, is a sufficient goal for most children in Tier 3. *Please see **Weight Loss** below for exceptions.*

- a. Continue to teach and model healthy and positive attitudes toward food and physical activity with minimal emphases on body weight for the entire family.
- b. Behavior techniques may also be needed to encourage healthy eating and physical activity behaviors.
- c. Intervention efforts should focus on maintaining weight such as:

1) Healthy eating behaviors for the entire family

- a. Portion size education
- b. Dietary Guidelines 2005
- c. Food Guide Pyramid for young Children and My Pyramid
- d. Bright Futures
- e. Ellyn Satter's Counseling Points

2) Encourage a diet high in fruits, vegetables and grains

3) Healthy eating environment for the entire family

- a. Involve child in healthy cooking and food preparation
- b. Encourage the family to eat together at the dinner table
- c. Allow adequate time to eat so not to rush to finish the meals
- d. Encourage the family to have healthy snack food available
- e. Encourage the family to recognize that food or the lack of food is not a good punishment or reward

4) Regular physical activity

- a. Encourage family outings to
- b. participate in regular every day activities.
- c. Encourage families to join into group activities.
- d. Assign active chores to the child such as vacuuming, washing the car, or mowing the grass.

- e. Encourage enrollment of the child into a structured activity at the YMCA such as gymnastics and martial arts.
  - f. Encourage the child to try a new sport. Reduce sedentary activities (e.g., watching television and videotapes, and playing computer games).
  - g. Limit screen time such as TV time, computer time, and other activities that limit physical activity.
- 3. Weight Loss—Tier 3 (BMI is 85<sup>th</sup> %, child is 7 years or older, and a medical complication such as mild hypertension, dyslipidemias, or insulin resistance exists). Please refer to Tier 4 for weight loss guidelines.
  - a. If warranted, weight loss should be limited to approximately 1 pound per month.
  - b. Approaches to treatment should remain focused on changing behaviors and lifestyle of the child/adolescent and family.
- 4. Weight loss Intervention--Tier 4 (BMI is 95<sup>th</sup> %)
  - a. Focus on prevention points and maintenance points above.
  - b. Encourage the family to maintain the child's weight.
  - c. Team should recommend additional changes in eating and activity to achieve weight loss of at least one pound per month, until they fall below the 85<sup>th</sup> percentile, with the primary goals of healthy eating and activity remaining.

**Note:** Intervention needs to be multidisciplinary and family centered.

B. Establish trust--work with family to identify weight goals.

1. Initial

- a. The first step in weight control for overweight children is maintenance of baseline weight--achieved through modest changes in diet and activity.
- b. Initial success can be the foundation for future changes.

2. Prolonged Weight Maintenance

- a. Allows for a gradual decline in BMI/percentile as children grow in height.

b. Sufficient goal for many children.

### 3. Weight Loss

- a. For children with a BMI at the 95<sup>th</sup> percentile or above—
  - i. The family is encouraged to demonstrate that they can maintain the child's weight
  - ii. Once weight is maintained, clinicians can recommend additional changes in eating and activity to achieve weight loss of at least one pound per month, until they fall below the 85<sup>th</sup> percentile
- b. The primary goal is healthy eating and activity

### **Counseling Points from Bright Futures:**

- Intervention should begin early.
- Start slowly. Ask families to suggest one or two changes, and then help them determine how to monitor the changes.
- Families will learn how to monitor eating and physical activity as part of the treatment process.
- Because weight maintenance is an important first step, families of children who have maintained their weight are praised for their success.
- The approach involves family members. The goal is to help family members achieve improved health behaviors rather than to single out the child.
- Treatment programs seek to institute lifestyle changes, avoiding short-term diets or physical activity programs aimed at rapid weight loss.
- Health professional encourages and empathizes rather than criticize. Because weight maintenance is an important first step, families of children who have maintained their weight are praised for their success.
- Children only should be placed on a restricted diet to lose weight for medical reasons, and will be closely supervised by a health professional.

### **Parenting Skills from Bright Futures:**

- Find reasons to praise child's behavior.
- Never use food as a reward--plan activities and special times together to reward desired behavior.
- Be consistent
- Establish daily times for family meals and snacks.
- Determine what types of foods are offered at what times, and allow the child to decide whether to eat.
- Allow children developmentally appropriate control of food.
- Offer healthy food options.
- Model health eating and physical activity, and make it fun.
- Limit the amount of time spent watching television and videotapes and playing computer games to 1 to 2 hours per day. Focus on ways to make television viewing more difficult.
- Assist the child in dealing with teasing or hurtful social situations resulting from overweight

### **Counseling Points from Ellyn Satter** (author of *Child of Mine*, *Feeding with Love and Good Sense*, and *How to Get Your Kid to Eat...But Not Too Much*):

- Use questions that help open a discussion with parents/family. Use both open-ended and specific questions to learn more about the child's feeding relationships and their current concerns. One open-ended question to encourage a discussion about feeding asks parents to list one thing they like and one thing they would like to change about their child's eating. Specific questions about parental feeding behaviors ask: whether and how often the family eat together, if the parent sits with the child when the child is eating, the extent to which parents let the child decide how much or how little to eat.
- Encourage families to serve regular meals and snack times for the child, and encourage family meal times as much as possible.
- Division of responsibility (Satter, *How to Get Your Kid to Eat...But Not Too Much*), parent is responsible for what, when, and where to eat. The child is responsible for how much and whether to eat.

- To be capable eaters, children must have support from adults:
  - Choose and prepare food
  - Have regular meals and snacks
  - Make eating time pleasant
  - Show the child what to learn
  - Not let the child graze for food or beverages between times
- Support includes trusting children's eating capabilities:
  - Children will eat
  - They know how much to eat
  - They will eat a variety
  - They will grow predictably
  - They will mature with eating

#### C. Provide training and materials

1. Use Ellyn Satter, and Bright Futures as resources.
2. See attached handouts and questionnaires.

### **Follow-up**

#### **Communication**

1. Instruct parents to call with questions and concerns.
2. Send copy of Initial Assessment and Nutrition Progress Notes to referral source, psychologist (if applicable), exercise physiologist (if applicable) and place in client's medical record.
3. Send reminder of next appointment one week before appointment. Call client 24-48 hours prior to next appointment to confirm.

## **Attachments**

- A. AHCCCS Childhood Obesity Guidelines
- B. AHCCCS Physical Activity Assessment Tool Questions
- C. Data to Be Obtained from a Food/Nutrition History Form
- D. Diet Record
- E. Recommendations for Weight Goals
- F. My Daily Food and Physical Activity Log
- G. Children's Physical Activity Chart
- H. AHCCCS Physical Activity Counseling Tools